

Medicare Crossovers

Medicare Crossovers

- Claims crossover automatic from COBC-GHI
- What does cross over
 - Institutional Claims
 - Professional Claims
- What doesn't cross over (exempt)
 - Part C
 - Hospice
 - Non-assigned Medicare claims
 - Adjustments from Medicare
 - NCPDP Claims

Claims That Do Not Crossover

- Options
 - Bill electronically with appropriate Medicare qualifiers and data included in transaction
 - Bill electronically with PWK indicator and send Medicare EOB as paperwork attachment
 - Bill on paper forms

Billing Medicare Electronically

- Medicare Paid Amount:
 - Loop 2430 Segment SVD Data Element 02
(Line Level)
- Medicare Coinsurance:
 - Loop 2430 Segment CAS Data Element 02, 05, 08, 11, 14, 17
Claim Adj Reason Code= 2
 - Amount Loop 2430 Segment CAS Data Element 03, 06, 09, 12, 15,18
- Medicare Deductible:
 - Loop 2430 Segment CAS Data Element 02, 05, 08, 11, 14, 17
Claim Adj Reason Code = 1
 - Amount Loop 2430 Segment CAS Data Element 03, 06, 09, 12,15,18

Paper Billing

- Institutional
 - Use form locators 39–41 for coinsurance and/or deductible
 - Paid amount in form locator 54
 - No EOB required for Paid Claims
 - Denials must have Medicare EOB with reason and remark codes description of reason and remark codes attached

Medicaid Only
Required Fields are Highlighted

Take Time Medical Center 104 Time Square Helena, MT 59601-0104		NPA PRTO # 4806 REG # Grisw97531 S PED TAG NO: 02/01/11 02/01/11 9912345	
PATIENT NAME: 111001111		PATIENT ADDRESS: 1313 Mockingbird Lane, Metropolis, MT 59601-1313	
GRISWOLD, CLARK DOB: 03/26/30 SEX: M DATE: 02/01/11 TIME: 11:11		01 0001 0002 0003 0004 0005 0006 0007 0008 0009 0010 0011 0012 0013 0014 0015 0016 0017 0018 0019 0020 0021 0022 0023 0024 0025 0026 0027 0028 0029 0030 0031 0032 0033 0034 0035 0036 0037 0038 0039 0040 0041 0042 0043 0044 0045 0046 0047 0048 0049 0050 0051 0052 0053 0054 0055 0056 0057 0058 0059 0060 0061 0062 0063 0064 0065 0066 0067 0068 0069 0070 0071 0072 0073 0074 0075 0076 0077 0078 0079 0080 0081 0082 0083 0084 0085 0086 0087 0088 0089 0090 0091 0092 0093 0094 0095 0096 0097 0098 0099 0100 0101 0102 0103 0104 0105 0106 0107 0108 0109 0110 0111 0112 0113 0114 0115 0116 0117 0118 0119 0120 0121 0122 0123 0124 0125 0126 0127 0128 0129 0130 0131 0132 0133 0134 0135 0136 0137 0138 0139 0140 0141 0142 0143 0144 0145 0146 0147 0148 0149 0150 0151 0152 0153 0154 0155 0156 0157 0158 0159 0160 0161 0162 0163 0164 0165 0166 0167 0168 0169 0170 0171 0172 0173 0174 0175 0176 0177 0178 0179 0180 0181 0182 0183 0184 0185 0186 0187 0188 0189 0190 0191 0192 0193 0194 0195 0196 0197 0198 0199 0200 0201 0202 0203 0204 0205 0206 0207 0208 0209 0210 0211 0212 0213 0214 0215 0216 0217 0218 0219 0220 0221 0222 0223 0224 0225 0226 0227 0228 0229 0230 0231 0232 0233 0234 0235 0236 0237 0238 0239 0240 0241 0242 0243 0244 0245 0246 0247 0248 0249 0250 0251 0252 0253 0254 0255 0256 0257 0258 0259 0260 0261 0262 0263 0264 0265 0266 0267 0268 0269 0270 0271 0272 0273 0274 0275 0276 0277 0278 0279 0280 0281 0282 0283 0284 0285 0286 0287 0288 0289 0290 0291 0292 0293 0294 0295 0296 0297 0298 0299 0300 0301 0302 0303 0304 0305 0306 0307 0308 0309 0310 0311 0312 0313 0314 0315 0316 0317 0318 0319 0320 0321 0322 0323 0324 0325 0326 0327 0328 0329 0330 0331 0332 0333 0334 0335 0336 0337 0338 0339 0340 0341 0342 0343 0344 0345 0346 0347 0348 0349 0350 0351 0352 0353 0354 0355 0356 0357 0358 0359 0360 0361 0362 0363 0364 0365 0366 0367 0368 0369 0370 0371 0372 0373 0374 0375 0376 0377 0378 0379 0380 0381 0382 0383 0384 0385 0386 0387 0388 0389 0390 0391 0392 0393 0394 0395 0396 0397 0398 0399 0400 0401 0402 0403 0404 0405 0406 0407 0408 0409 0410 0411 0412 0413 0414 0415 0416 0417 0418 0419 0420 0421 0422 0423 0424 0425 0426 0427 0428 0429 0430 0431 0432 0433 0434 0435 0436 0437 0438 0439 0440 0441 0442 0443 0444 0445 0446 0447 0448 0449 0450 0451 0452 0453 0454 0455 0456 0457 0458 0459 0460 0461 0462 0463 0464 0465 0466 0467 0468 0469 0470 0471 0472 0473 0474 0475 0476 0477 0478 0479 0480 0481 0482 0483 0484 0485 0486 0487 0488 0489 0490 0491 0492 0493 0494 0495 0496 0497 0498 0499 0500 0501 0502 0503 0504 0505 0506 0507 0508 0509 0510 0511 0512 0513 0514 0515 0516 0517 0518 0519 0520 0521 0522 0523 0524 0525 0526 0527 0528 0529 0530 0531 0532 0533 0534 0535 0536 0537 0538 0539 0540 0541 0542 0543 0544 0545 0546 0547 0548 0549 0550 0551 0552 0553 0554 0555 0556 0557 0558 0559 0560 0561 0562 0563 0564 0565 0566 0567 0568 0569 0570 0571 0572 0573 0574 0575 0576 0577 0578 0579 0580 0581 0582 0583 0584 0585 0586 0587 0588 0589 0590 0591 0592 0593 0594 0595 0596 0597 0598 0599 0600 0601 0602 0603 0604 0605 0606 0607 0608 0609 0610 0611 0612 0613 0614 0615 0616 0617 0618 0619 0620 0621 0622 0623 0624 0625 0626 0627 0628 0629 0630 0631 0632 0633 0634 0635 0636 0637 0638 0639 0640 0641 0642 0643 0644 0645 0646 0647 0648 0649 0650 0651 0652 0653 0654 0655 0656 0657 0658 0659 0660 0661 0662 0663 0664 0665 0666 0667 0668 0669 0670 0671 0672 0673 0674 0675 0676 0677 0678 0679 0680 0681 0682 0683 0684 0685 0686 0687 0688 0689 0690 0691 0692 0693 0694 0695 0696 0697 0698 0699 0700 0701 0702 0703 0704 0705 0706 0707 0708 0709 0710 0711 0712 0713 0714 0715 0716 0717 0718 0719 0720 0721 0722 0723 0724 0725 0726 0727 0728 0729 0730 0731 0732 0733 0734 0735 0736 0737 0738 0739 0740 0741 0742 0743 0744 0745 0746 0747 0748 0749 0750 0751 0752 0753 0754 0755 0756 0757 0758 0759 0760 0761	

Full Column

ONS ADDITIONAL FENDING

NURC NUCLEAR REGULATORY COMMISSION **U.S. NUCLEAR REGULATORY COMMISSION**

Full Column

Required Fields
Conditional Fields
Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

Medicaid Only
Required Fields are Highlighted

[illegible]

Paper Billing

- Bill on paper claim forms
 - Professional
 - Do not enter Medicare information on 1500
 - No Medicare paid amount in field 29
 - Attach a copy of the Medicare EOB for all paper claims submitted
 - Include Reason and Remark code description for all Medicare denials

TPL

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

Medicaid Only Coverage

Fill Colors:

- Required Fields
- Conditional Fields
- Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FICA OTHER P (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (SSN) (ID)												FICA											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Flintstone, Fred T						3. PATIENT'S BIRTH DATE 08 30 1960 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>						10. INSURED'S I.D. NUMBER (For Programs 10, 11, 12)											
5. PATIENT'S ADDRESS (No., Street) 112 Rocky Rd.						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S NAME (Last Name, First Name, Middle Initial)											
8. CITY Bedrock						9. STATE BC						11. INSURED'S ADDRESS (No., Street)											
12. ZIP CODE 54321-1234						13. TELEPHONE (Include Area Code) (406) 765-4321						14. CITY											
15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						16. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						17. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
18. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						19. EMPLOYER'S NAME OR SCHOOL NAME						20. EMPLOYER'S NAME OR SCHOOL NAME											
21. INSURANCE PLAN NAME OR PROGRAM NAME						22. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 18.</i>						23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
24. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												25. SIGNED											
26. DATE MM DD YY												27. SIGNED											
28. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pre-natal/Lump) MM DD YY												29. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY											
30. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo MD												31. ID: 9954321 32. NPI: 1324675908											
33. RESERVED FOR LOCAL USE												34. RESERVED FOR LOCAL USE											
35. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by ICD) 780.60												36. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.											
37. PRIOR AUTHORIZATION NUMBER												38. PRIOR AUTHORIZATION NUMBER											
39. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.												40. FEDERAL TAX I.D. NUMBER 99-9999999		41. PATIENT'S ACCOUNT NO. BV12345		42. ACCEPT ASSIGNMENT? (For grant, assign, one-time) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		43. TOTAL CHARGE 100.00		44. AMOUNT PAID 85.00		45. BALANCE DUE 100.00	
46. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Ricky Shalstone MD 01/01/11 SIGNED DATE												47. SERVICE FACILITY LOCATION INFORMATION Yabba-Dabba Center 2121 Granite Slab Dr. Bedrock, BC 54321-1234		48. BILLING PROVIDER INFO & ID # 1876543215		49. NPI 1213456789							

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-093

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Part C Medicare HMO Plans

- Currently processed as Medicare Part B claims
 - Copay amounts entered as deductible
 - Coinsurance entered as coinsurance
 - Deductible entered as deductible
 - Deductible + Coinsurance + Copay entered as deductible
- Claims processing system cannot process Medicare correctly without a Medicare paid amount if a coinsurance is present
 - Medicare paid and deductible/coinsurance all considered in pricing formula

Common Issues Resulting in Denials

- Client has Medicare on file and no Medicare information is present on claim
- Medicare denied service as not medically necessary
- Medicare EOB and claim do not match
 - Check
 - Client, date of service, billed amount, and procedure code
- Medicare denial reasons are not attached

Common Issues Resulting in Denials

- Medicare denied as a duplicate
- Medicare denied for a billing error
- Medicare denied for timely filing
- Medicare denied for service not paid separately
- Medicare denied because service paid by another payer

Third Party Liability

TPL Responsibilities

- Insurance verification
- Assist with problem claims
- Retro Medicare
- Carrier billing
- Provider checks/refunds
- Credit balance
- Trauma investigations

Services to You

- Pay and Chase
 - 90-Day Rule – Providers can request that Montana Health Care Programs process the claim and subsequently bill the other payer.
 - Specific circumstances result in automatic pay and chase.
 - Some prenatal and pediatric codes

Billing TPL Electronically

- TPL Information
 - Loop 2320 Segment SBR Data Element 09
- TPL Payment
 - Loop 2320 Segment AMT Data Element 02

Blanket Denial

- Include documentation that the client's other insurance never pays for a particular service.
- Requests are available on the web or from TPL. Complete and return requests to TPL. Fax to 406-442-0357.
- In return you will receive the blanket denial along with a tracking reference number to be used for billing.

Request for Blanket Denial Letter

Xerox State Healthcare, LLC • State of Montana Medicaid

Effective Date Requested _____ Provider/NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____

2. _____

3. _____

4. _____

5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Fax all requests to Xerox State Healthcare, LLC, at (406) 442-0357.

Request must include an explanation of benefits (EOB) stating the services are not covered.

How to Bill using a Blanket Denial

- Xerox staff work TPL edits that post for which a blanket denial has been created.
 - Electronic claims: include *pwk* indicator
 - Paper claims: send the claim only
- Blanket denials are valid for two years from date on the request. Renewals must be requested and are not automatic.

Common Problems

- No TPL amount on the claim
 - If you have information TPL has termed, please call Provider Relations at 1-800-624-3958
- Medicare information is put in as a TPL amount
- No paperwork attachments

Phone Number Read as TPL

Medicaid Only Coverage											
HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
<div> <div>1500</div> <div> <div>Fill Colors:</div> <div> <div>Required Fields</div> <div>Conditional Fields</div> <div>Other</div> </div> </div> <div> <div>Border Colors</div> <div> <div>Client Fields</div> <div>Provider Fields</div> <div>Billing Fields</div> </div> </div> </div>											
<div> <div>1. MEDICARE MEDICAID MEDIGAP CHAMPVA GROUP HEALTH PLAN FEDA BULKING OTHER</div> <div> <div>(Medicare #)</div> <div>(Medicaid #)</div> <div>(Medigap #)</div> <div>(Champion's SSN)</div> <div>(Member ID#)</div> <div>(SSN or ID)</div> <div>(SSN)</div> <div>(ID)</div> </div> </div>											
<div> <div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>Plintstone, Fred T</div> </div>											
<div> <div>3. PATIENT'S BIRTH DATE</div> <div>08 30 1960</div> </div>											
<div> <div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div></div> </div>											
<div> <div>5. PATIENT'S ADDRESS (No., Street)</div> <div>112 Rocky Rd.</div> </div>											
<div> <div>6. PATIENT RELATIONSHIP TO INSURED</div> <div>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></div> </div>											
<div> <div>7. INSURED'S ADDRESS (No., Street)</div> <div></div> </div>											
<div> <div>8. PATIENT STATUS</div> <div>Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/></div> </div>											
<div> <div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div></div> </div>											
<div> <div>10. IS PATIENT'S CONDITION RELATED TO</div> <div>Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></div> </div>											
<div> <div>11. INSURED'S EMPLOYER OR SCHOOL NAME</div> <div></div> </div>											
<div> <div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</div> <div></div> </div>											
<div> <div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</div> <div></div> </div>											
<div> <div>14. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>											
<div> <div>15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM MM DD YY TO MM DD YY</div> </div>											
<div> <div>16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM MM DD YY TO MM DD YY</div> </div>											
<div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>Great Gazoo MD</div> </div>											
<div> <div>18. RESERVED FOR LOCAL USE</div> <div></div> </div>											
<div> <div>19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</div> <div>780 .60</div> </div>											
<div> <div>20. OUTSIDE LAB?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>											
<div> <div>21. MEDICAID RESUBMISSION CODE</div> <div></div> </div>											
<div> <div>22. PRIOR AUTHORIZATION NUMBER</div> <div></div> </div>											
<div> <div>23. PROVIDER IDENTIFICATION NUMBER</div> <div></div> </div>											
<div> <div>24. A. DATE(S) OF SERVICE</div> <div>From MM DD YY To MM DD YY</div> </div>											
<div> <div>25. FEDERAL TAX ID NUMBER</div> <div>99-9999999</div> </div>											
<div> <div>26. PATIENT'S ACCOUNT NO.</div> <div>BV12345</div> </div>											
<div> <div>27. ACCEPT ASSIGNMENT?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div>											
<div> <div>28. TOTAL CHARGE</div> <div>100.00</div> </div>											
<div> <div>29. AMOUNT PAID</div> <div>406.555.1234</div> </div>											
<div> <div>30. BALANCE DUE</div> <div>100.00</div> </div>											
<div> <div>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</div> <div>Rocky Shalstone, MD</div> </div>											
<div> <div>32. SERVICE FACILITY LOCATION INFORMATION</div> <div></div> </div>											
<div> <div>33. BILLING PROVIDER INFO & PI #</div> <div>Yabba-Dabba Center</div> </div>											
<div> <div>34. BILLING PROVIDER INFO & PI #</div> <div>2121 Granite Slab Dr.</div> </div>											
<div> <div>35. BILLING PROVIDER INFO & PI #</div> <div>Bedrock, BC</div> </div>											
<div> <div>36. BILLING PROVIDER INFO & PI #</div> <div>54321-1234</div> </div>											
<div> <div>37. BILLING PROVIDER INFO & PI #</div> <div>1876543215</div> </div>											
<div> <div>38. BILLING PROVIDER INFO & PI #</div> <div>ZZ</div> </div>											

Medicaid Entered as Other Insurance

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05											
1500											
Medicaid Only Coverage											
Fill Colors:											
Border Colors											
Client Fields											
Provider Fields											
Billing Fields											
Other											
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FFCA BIKLING OTHER (Medicare #) (Medicaid #) (Tricare #) (Champus #) (Member ID) (SSN or ID) (SSN) (ID) (ID)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
Flintstone, Fred T				08 30 1960 M X F							
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)			
112 Rocky Rd.				Self X Spouse Child Other							
CITY				8. PATIENT STATUS				CITY			
Bedrock				Single Married X Other							
STATE				9. EMPLOYMENT? (Current or Previous)				STATE			
BC				Employee X Full-Time Student Part-Time							
ZIP CODE				10. IS PATIENT'S CONDITION RELATED TO				ZIP CODE			
54321-1234				Employer X Full-Time Student Part-Time				()			
TELEPHONE (Include Area Code)				11. INSURED'S POLICY OR CONTRACT NUMBER				TELEPHONE (Include Area Code)			
(406) 765-4321								()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO				11. INSURED'S DATE OF BIRTH			
				a. YES b. NO				MM DD YY M F			
				c. AUTO-ACCIDENT? d. OTHER ACCIDENT?				12. EMPLOYER'S NAME OR SCHOOL NAME			
				e. YES f. NO				Medicaid			
13. INSURANCE PLAN NAME OR PROGRAM NAME				14. IS THERE ANOTHER HEALTH BENEFIT PLAN?				15. INSURANCE PLAN NAME OR PROGRAM NAME			
Medicaid				X NO If yes, return to and complete item 9 and 10.							
16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE											
Great Gazoo MD											
18. DATE OF CURRENT ILLNESS (First symptom or injury) (Reported or Physician's Date)											
01 01 09											
19. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE											
17a. ID: 9954321 17b. NPI: 1324675908											
20. HOSPITALIZATION DATE TO CURRENT SERVICES											
FROM TO											
21. OUTSIDE LAB? YES X NO											
22. MEDICARE RESUBMISSION CODE ORIGINAL REF NO											
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.											
25. FEDERAL TAX ID NUMBER: 99-9999999											
26. PATIENT'S ACCOUNT NO: BV12345											
27. ACCEPT ASSIGNMENT? YES X NO											
28. TOTAL CHARGE: \$ 100.00											
29. AMOUNT PAID: \$ 100.00											
30. BALANCE DUE: \$ 100.00											
31. BILLING PROVIDER INFO & TIN # (406) 555-1234											
Yabba-Dabba Center											
2121 Granite Slab Dr.											
Bedrock, BC 54321-1234											
32. SERVICE FACILITY LOCATION INFORMATION											
33. BILLING PROVIDER INFO & TIN # 1876543215 ZZ 400RT0010X											
34. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made in partnership.)											
Rocky Shalstone, MD 01/01/11											
NUCC Instruction Manual available at: www.nucc.org											
APPROVED CMB-0938-0999 FORM CMS-1500 (08/05)											

What Should I Send to TPL?

- Problem TPL claims
- 90-day pay and chase claims
- Verification requests from TPL
- Blanket denials
- Refund checks
 - Note if it's for credit balance

Contact Information

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Questions

